THE CHILD

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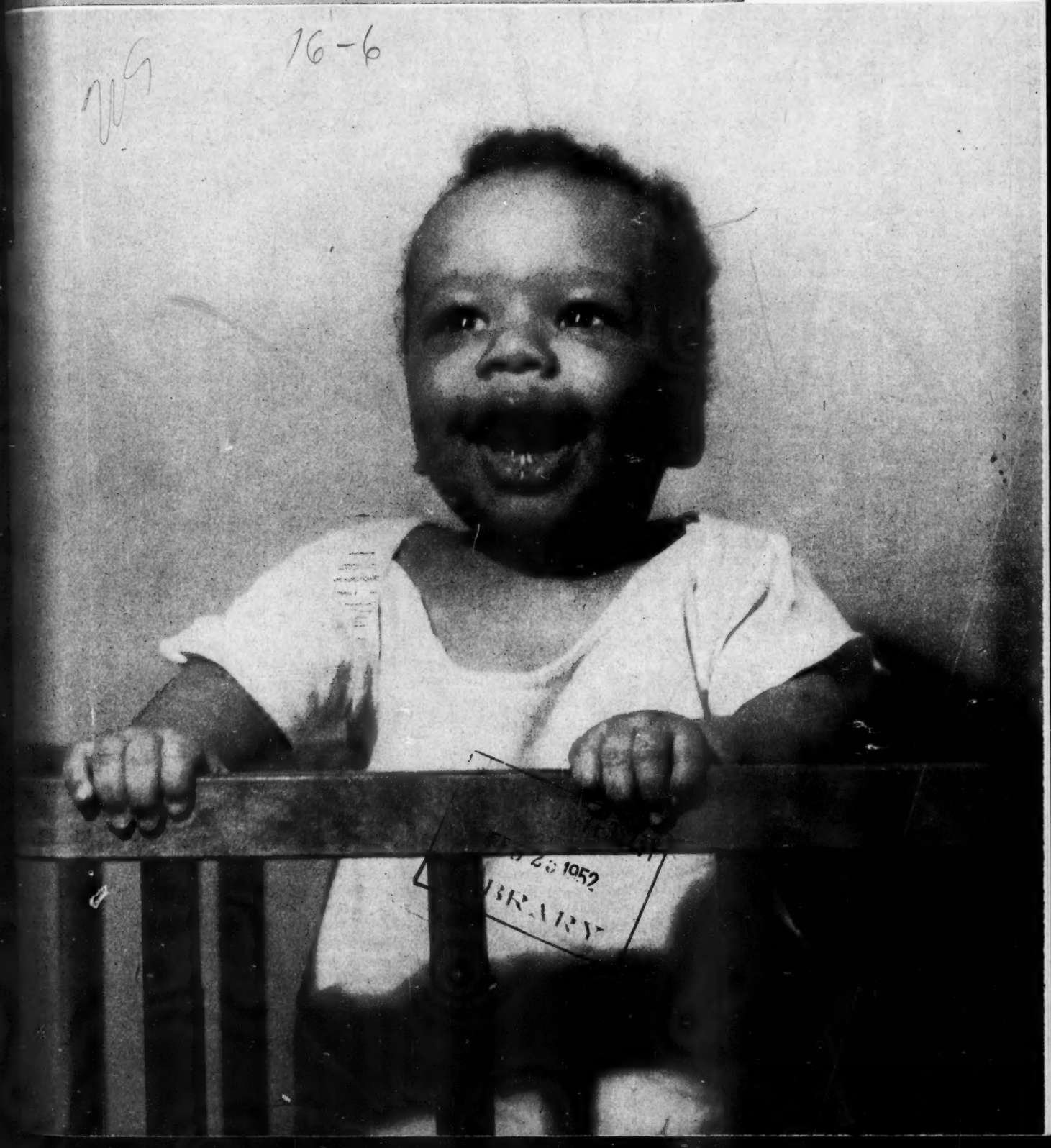

FOR THE CHILD WHO MUST LIVE AWAY FROM HIS OWN HOME

SPENCER H. CROOKES

ALL OVER the United States child-care agencies are making sound progress in improving foster care for children—care of the child outside his own home, whether in an institution, a boarding home, or the home of a family that plans to adopt him.

The great need that still exists for such care shows that we have not yet succeeded in carrying out the principle set by the first White House Conference on children (1909). That conference declared that "home life is the highest and finest product of civilization," and urged that "children should not be deprived of it except for urgent and compelling reasons."

Home life, said the first White House Conference, is the highest and finest product of civilization. Children should not be deprived of it except for urgent and compelling reasons.

To keep children in their homes

It is true that the Federal-State program of Aid to Dependent Children is taking a long step toward carrying out that principle, for it is now keeping more than a million and a half children in their own homes who otherwise would have to be placed elsewhere. [See Jane M. Hoey's article in this issue of **The Child**, "Aid to Dependent Children Keeps Homes Together."—ED.]

But pressure of numbers still confronts children's agencies.

The United States now has more than 47 million children under 18 years of age, the largest child population in our history. The birth rate is continuing to rise.

More women with children are entering employment. Family breakdowns seem to be increasing. And the housing shortage has added to the need for foster care for children.

In 1950 about 7 million children under 18 were living with only one parent or with neither parent—the majority of these children from families disrupted by death, divorce or separation.

As early as 1945 we began to see a change in the problems of the children that need foster-care services. More difficult problems appeared, problems that increasingly reflected parental incapacity or irresponsibility. A greater proportion of the children came from broken homes. This change has been leading to changed types of services.

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This article was based by Mr. Crookes on a paper that he gave at the seventy-seventh annual meeting of the National Conference of Social Work.

New types of services needed

Right now we find that more children than ever before are presenting problems that do not respond to traditional methods, that our funds in inflated dollars will not pay for the increased and improved services that these children need, and that the public's lack of information about such conditions makes it difficult to obtain the necessary services.

As to the attitude of the public toward foster-care services, we see a tendency on the part of the people as a whole to link in a single mental picture both voluntary and public services. Thus, the growing concern over "extension of welfare pro-

grams" tends to depress, in both types of agency, already insufficient services for children.

Good child care has become increasingly expensive; and there is little likelihood that the expense can be reduced. The people have not been sufficiently informed as to what services are required for good child care; and so they do not realize how much it costs.

In community after community we of the Child Welfare League find that the vast majority of people continue to think of child welfare in terms of "orphans" or "homeless waifs." They do not know what we mean when we refer to a good foster-family program, and few indeed know the basic tenets of good institutional care and of adoption. In addition, they believe that any well-intentioned individual who likes children can carry out the highly skilled techniques that go to make up specialized child-welfare services.

We have failed to explain such services to the public, and we have failed to make clear how important are adequate grants of Aid to Dependent Children and adequate case-work service in such aid and in general public assistance. And as a result we have compounded our foster-care problems. The blame for such failures rests with no one group; we are all at fault for having failed to keep the public informed.

Institutional care now fitted to individuals

Increasingly, institutional care and foster-family care are recognized as complementing each other in a child-welfare program. We see signs that both institutional people and those sponsoring other forms of foster care are willing to change. The latter now say to the institutions in effect: "We appreciate the place that group living has in child care; we urgently need your help in handling children who would benefit from that kind of setting."

We went through a long period during which the sponsors of foster-family care heralded the end of institutions. Institutional people were inclined to withdraw behind their walls and to divorce themselves from planning and responsibility for community programs in general. Today we see a renaissance, in which institutions are undertaking to care for children with special emotional and behavior problems in ways that seem to tend toward direct diagnostic study and treatment. There is now hardly a community of over 250,000 population that has not, or is not seeking, special treatment programs for such children, as a result of the requests of social agencies. Many such programs, it is true, do not have the basic resources that are needed. Nevertheless we know that institutions will continue to treat children with problems.

Satisfactory general categories have been established as to the kinds of children needing institutional placement. For example, we have gone beyond the point of believing that all adolescents respond well to institutional care. Choosing the kind of help children need depends upon knowledge of the individual child and his situation. And choosing the place to send him for this help depends on what the available institutions or other resources have to offer.

In line with the present use of the institution, congregate buildings are being replaced, wherever this is possible, by cottages. Until recently, cottage units of 10 or 12 children were the smallest considered. Now some institutions are considering units that would provide for as few as 6 children; here, increased costs of program and staffing demand careful selection of children for this type of care, on the basis of their special needs. Some institutions have remodeled their congregate buildings as apartment units, which offer some of the advantages of the cottage plan as well as those of a congregate building. These units include not only bedrooms, but also living rooms and dining facilities, served by small kitchens.

Along with this changing emphasis in the use of institutions for specialized types of group care has come an increasing consciousness that until a different status can be achieved for the cottage parent in an institution, specialized programs are all but dreams. What is involved here is not only to redefine the job of houseparents so that each is an associate in the task of caring for children, rather than simply an overworked custodian, but also to establish adequate rates of pay, and, especially, to offer training programs that will help them to know more about children. A cottage parent needs not only managerial ability and qualities of leadership, but also the ability to understand children and their behavior in special circumstances.

It is not only by chance that one of the most consistent demands made of the Child Welfare League has been for training programs for houseparents, providing more than brief refresher institutes. A few such programs have been worked out, but they merely scratch the surface of the need.

Fewer children in institutions

Another factor that has contributed sharply to changes in institutional programs has been the decrease in the number of children in institutions. This has been largely the result of extension of other types of community resources, including foster-family care and provision of financial assistance and service to children in their own homes. Also agencies are doing a better job of selecting the children who can profit best by institutional experience. The institutions also realize how inefficient it is to use their costly facilities for custodial care of children who can be cared for better in selected foster-family homes.

Another development is that fewer babies and preschool children are placed in institutions. A policy long believed in by the League has been more and more widely accepted—that babies need the individual kind of care usually to be had only in a family home.

Also, the belief that case work is an essential part of the program of a good institution has found new adherents. This is not to say that all institutions either accept modern institutional methods or even admit that case work can play a role in effective institutional care. But we of the League are being called upon more than ever before to consult with institutions anxious to change to the best methods known.

What of developments in foster-family care? Of the thousands of children cared for outside their own homes, whether placed by voluntary or by public agencies, an increasing proportion are in foster-family homes. Many agencies are now introducing foster-family care as an adjunct to an institutional-placement program. Some family-welfare agencies are adding child-placing services to their functions. Another factor in the increasing use of foster-family homes is the greater availability of boarding homes, a result of improved agency staffing and higher payments for board. It is estimated that not less than 55 percent of the children cared for outside their own homes are in boarding homes.

Of the many other developments in foster-family care, three should be noted:

Emphasis is being placed on programs for recruiting foster homes. Although increased boarding rates and additional staff have made more homes available, a dearth continues. Housing shortages, costs, and higher incomes are given as causes, and some people think the saturation point has been reached.

Experience of agencies planning recruitment shows that we should keep several factors in mind: (1) Foster-home recruitment should be sustained if it is to be effective. (2) Staff time must be allocated for the purpose of following up queries. (3) Volunteers can be used effectively in home-finding campaigns to explain the situation, if given training. (4) Accompanying recruitment should be activities geared to give status and recognition to the foster parents, both as a means of making foster care understood and also of utilizing the best recruiters of all — the foster parents themselves.

Stress value of good foster parents

In an effort to keep good foster homes, agencies are emphasizing the part of foster parents in the over-all social services. Like cottage houseparents in an institution, who are charged with 24-hour responsibility for care and emotional nurture of children, foster parents are key figures. A successful foster-home program cannot be operated on a "place-and-run" basis. Agencies are accepting more responsibility for their share in the life of the child in a foster home, and are undertaking case work with the parents. They are also recognizing the special contributions of foster parents. I suspect that many good foster homes would not be lost if we helped them enough with the care of the children we send them, many of whom are bursting with problems.

Just a word about board rates. Information at the League indicates a steady increase in most parts of the country. The range is from $25 to $65, which means that in some places rates are below actual cost of care, and in others small service fees are being added to the actual costs. A firm conviction of the importance of reimbursing foster parents, at least for the actual cost of care, is growing. The obvious truth is that they cannot be repaid for the time, effort, and nervous energy involved.

Another development in foster-family care is the increasing use of subsidized boarding homes. One type is for temporary care of infants, in preparation for adoption or return to their parents. Similarly, interest has increased on the part of State divisions of child welfare in the use of available Federal funds for subsidized homes for temporary care of children, pending study or investigation.

Child-welfare agencies are trying more and more to select and hold trained foster parents, capable of working successfully with children whose behavior problems are more than ordinary ones. Such homes have been used in observing the behavior of children and making plans for them.

Another type of subsidized home is that developed as a residence club for adolescent girls or boys. Here, under supervision by an agency, trained foster parents work with adolescents who find it difficult to adjust in an average foster home or institution.

Recently, Federal funds for child-welfare services have been budgeted by States for subsidizing boarding homes that care for unmarried mothers and their children. It must be recognized, however, that such resources should be used, not as a substitute for Aid to Dependent Children, but only when care in a boarding home seems to be the plan most suited to the needs of the mother and child.

We can help a parent to help the child

Most important is the growing stress on providing service to the **parent,** as essential to providing service to the **child.** Agencies are departing from the concept that the job of the institutional worker or the foster placement worker is limited to contact with the child in his new place. This is one of the most encouraging developments in child-welfare thinking today, and possibly takes us a long step toward protecting for the child his right to establish permanent roots in a home of his own.

Two areas of need in foster-family care are especially urgent: Negro children, because of discriminatory programs, have not had adequate service. Also, in our rural population, large numbers of children have not yet been reached by State-wide public or voluntary services.

In the last few years the social aspects of adoption have received much attention. During that time

more than half the States have re-enacted or amended their adoption laws, and there has been a growing tendency to recognize the need for adequate legislation to protect not only the child, but the natural parents, and also the couple that plans to adopt the child.

But good adoption legislation is not enough. The most progressive statutes will be ineffective without the services and facilities necessary to carry out their purpose and intent. Legal protection for the child will not be genuine even though the law requires that every family petitioning to adopt a child be studied by a "recognized agency," unless that agency has the essential equipment for doing the job. This means strengthening staff as well as allowing more leeway for stronger administrative support of an important service. It also means that a well-equipped adoption agency will be as ineffective as one that is not well-equipped unless it can enter the picture early—not merely when an adoption is all but accomplished.

Nor can we overlook the importance of our "basic" services in connection with a more effective adoption program. If we stop and think about the essential connection between good adoption services and other standard social services, we see that their interdependence is likely to be overlooked. It is impossible to maintain a good adoption program when general public assistance, family service, Aid to Dependent Children, medical services, and placement services are inadequate.

It is estimated that for every child available for adoption there are at least 15 couples asking for a child. Private agencies cannot hope to provide all the services demanded by the great number of families applying for adoptive children; public agencies must assist. We **cannot** use the main part of our voluntary funds in order to provide the needed adoption services to the exclusion of other kinds of foster care.

Serious problems, however, can accompany development of public adoption services, not the least of which is the tendency to take up such specialized and skilled functions before other basic public child-placing services are functioning effectively. Many States, under pressure to provide adoption services, are strongly concerned lest such a move jeopardize a well-rounded program of social services for children, under public auspices.

A baby especially needs the individual care that is usually to be found only in a family home.

Many more agencies are charging fees to couples applying for children, so as to pay for at least part of this service. Fees range from a token payment of $15 to $500. One agency reports fees ranging up to $1,200 — the total cost. It must be conceded, however, that the use of fees by standard adoption agencies is in an experimental stage. Whether it succeeds will depend upon the quality of staff and the degree of acceptance by the community. The latter in turn depends on how clearly the agency explains the system.

Recently favorable and unfavorable publicity in regard to adoption has been renewed in the press and national magazines. This interest in adoptions can become mass hysteria concerning all social services provided by standard agencies; or it can be converted into real public education, if we are able and willing to use the opportunity. In the public mind adoption services bid fair to represent all organized social services for children, and child-welfare agencies therefore are directly challenged by public doubts.

When a mother works outside the home

One aspect of foster care which is rapidly taking a large place in the mosaic of community resources is the day-care center. In the past, day care was generally considered a somewhat unproductive pursuit of charity-minded ladies. More recently, however, despite the fact that community support has been slow, day care has been increasingly recognized. This is a logical outgrowth of the conviction on the part of placement agencies that a child should not be removed from his parents if there is strength in the family on which to build. This means that more and more agencies

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AID TO DEPENDENT CHILDREN KEEPS HOMES TOGETHER

JANE M. HOEY

EVEN in prosperous times, many families with children have a hard time making ends meet, particularly since incomes tend to be lowest in homes where children are most numerous. Nevertheless, when father and mother pull together and when children share in the family job of penny-stretching, many a home can be healthy and happy on a surprisingly small income. Each treat is enjoyed all the more because it represents a triumph in the battle against poverty.

From generation to generation

But if the family's annual income is as low as $2,000, or less—and one out of five children in the United States lived in such families in 1950—the contest is often too grim to be fun. The bad housing and malnutrition that go along with low income often endanger health. Hope for a better future is dimmed by the dreary struggle for daily existence. When this happens, a family may sink into a Slough of Despond, and it may no longer seem important whether or not the children go to school and church regularly; or what traits of character they develop; or how or where they seek amusement. Under such conditions children frequently grow up to be social problems instead of wholesome, useful members of society. As adults, they, in turn, raise their children under unwholesome conditions, and the chain of trouble carries on from one generation to the next.

For years this problem has confronted social workers, teachers, nurses, church workers, and others concerned with the health and welfare of children. Frequently they have broken the vicious chain by giving the family or some member of it the encouragement and specialized help that make a better life possible. All too often, however, their efforts have been thwarted because the economic need was too overwhelming. The family needed the services these workers could give, but could make little use of them unless the fundamental needs of food, clothing, and shelter were also met.

Certain provisions of the Social Security Act, passed in 1935 and subsequently amended, aim to fulfill these fundamental needs. The social-insurance provisions and those dealing with public assistance authorize Federal aid for programs specifically designed to prevent the most extreme and abject poverty.

The social-insurance programs include (1) Old-Age and Survivors Insurance, which enables many workers to provide an income for themselves and their families when their earnings are cut off by old age or death, and (2) Unemployment Insurance, which provides income during periods of unemployment.

The public-assistance programs provide aid for some of the people who are not covered by social insurance and who are too old, or too young, or too disabled to earn a living for themselves. Originally the public-assistance provisions included three programs: Old-Age Assistance, Aid to Dependent Children, and Aid to the Blind. In 1950, through an amendment to the Social Security Act, a fourth program was added, Aid to the Permanently and Totally Disabled.

Stimulated by the availability of Federal aid, the States set up their own public-assistance programs, or adapted their existing programs to the Federal requirements, and defined the standard of living that would be maintained for needy people receiving assistance. Since each State had to put up matching funds in order to receive Federal aid, poor States could not afford to set their standards as high as rich States, and often had to be more stringent in defining what resources would render people ineligible for aid. Even though the programs were so different in the various States, a planned attack against poverty went forward throughout the country.

The small cash public-assistance payment many people—elderly men and women, blind and disabled individuals — receive regularly from their county or State public welfare office prevents their needing services that would be more costly. Likewise, children who might have become juvenile-court problems get parental supervision. Their mothers, managing on Aid to Dependent Children payments, need not go out to work.

For some people, however, this economic aid has not been enough. They are the ones who, because of mental or emotional handicaps,

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Miss Hoey was alternate representative of the United States to the sixth session of the Social Commission of the Economic and Social Council of the United Nations. She also served as the United States representative to the seventh session of that Council, held in Geneva, Switzerland, in 1951.

need a variety of special services. Among these people are still found the problems that have long concerned workers in all aspects of the child welfare field — the children who are truants from school, the delinquent adolescents, the fathers who desert their families, the mothers who are slovenly housekeepers. Part of the economic problems in some such families are now being met through the Aid to Dependent Children program; but workers in this program, with heavy case loads and little professional training, have not been able to provide the multitude of services that might lift these families—or at least the children—onto a higher plane of living. Nor have services from other sources, for health, welfare, education, religion, recreation, and so forth, been able to fill the gap. A floor has been put under poverty—though in many areas it is a thin and shaky one—but measures to cope with related problems have not been stressed equally.

From one standpoint, it could be said that there is nothing new or alarming in this situation. There have never been sufficient services to meet the needs of all the maladjusted.

From another standpoint, however, we can see that the lag between efforts to meet economic need and efforts to meet social need has already produced serious consequences, for it has led to public misunderstanding about the Aid to Dependent Children program.

Because antisocial behavior is always more conspicuous than is conventional behavior, the public tends to identify all families who receive public aid with the few families whose needs are complicated by the fact that some member does not behave in a socially approved manner, such as the father who deserts his family, the mother who neglects her children, or the daughter who has a baby born out of wedlock. Some people, not recognizing the underlying causes of such behavior, believe that the public-assistance program contributes to it.

Under the impression that public assistance saps the moral character of those who receive it, some people think the problem can be solved by introducing restrictive measures. Such measures, aimed at punishing maladjusted adults, inevitably bring hardship to needy children. Equally serious, and of even more concern to professional workers in the child-welfare field, is the fact

FACTS ABOUT ADC

PURPOSE OF PROGRAM. To enable needy children to live in their own home and to receive care, affection, and supervision from a parent or close relative.

SIZE OF PROGRAM. 1.5 million children, or about 3 percent of all the children in the United States under 18 years of age are totally or partly dependent on Aid to Dependent Children.

COST OF PROGRAM. Out of the national income dollar less than three-tenths of a cent goes for Aid to Dependent Children payments. Total cost in 1951 was $568 million; this includes Federal, State, and local funds.

HOW FINANCED. The Federal Government will pay three-fourths of the first $12 paid, per person per month, plus half of the balance of all expenditures up to $27 for the mother or other caretaker, $27 for the first child, and $18 for each additional child. The remainder is paid from State funds or from combined State and local funds.

ELIGIBILITY. The program is limited to needy children whose wage-earning parent is dead, incapacitated, or absent from home. Each State establishes its own definition of need and sets its own terms about requiring families to exhaust other resources, including support from relatives, before becoming eligible for aid.

PERIOD WHEN AID CAN BE GIVEN. Children can be aided until they are 16, or 18 if still in school. However, the average length of time aid is needed is estimated to be less than 3 years.

RESULTS OF PROGRAM. Follow-up studies made in several communities show that most children aided in the early years of the program have developed into stable, tax-paying citizens. Where school-attendance records have been studied, it has been found that the attendance of children who have received assistance under the program for Aid to Dependent Children tends to be higher than that of the general school-age population.

HOW YOU CAN HELP. Study these facts and tell others about them. Learn more about the program in your own community from your local welfare office.

that, if the belief prevails that withdrawal of financial aid will solve social problems, ways of arriving at more basic solutions will continue to be neglected.

One way to approach these problems is to try to prevent them from developing. A tremendous step in this direction would be more low-cost housing and more slum clearance. Other helps would be more day-care centers for children of working mothers, more social case work for children in their own homes, more foster homes, and more child-guidance clinics. These and other facilities and services would help to salvage children now growing up in bad environments. But to deny to them aid in their own homes, however poor these homes may be, when better ways of aiding them are unavailable, adds to their deprivation and intensifies their problems.

Social services make aid go farther

If the people as a whole can gain a better understanding of public assistance they will realize more clearly that the programs protect only minimum living standards among the 3½ percent of our population receiving such assistance, and that this small help prevents much suffering. And better understanding of the nature of the problems that public-assistance programs are trying to meet will lead people to support more strongly the various public and private services that enhance economic aid.

We already see countless indications that underprivileged children are the victims of lack of public understanding. Several States are making plans to publish the names of all persons receiving assistance. Advocates of this procedure do not really want to expose sensitive children to the jibes of their classmates, but they think it is the only way to get rid of the many "chiselers" that they have been led to believe are receiving public aid.

Several special investigations, conducted by States and cities where a large amount of "chiseling" was suspected, have revealed that the total number of ineligibles receiving aid is less than 3 percent of the total. And some of these had become ineligible only through changes in State laws. The actual number of fraudulent cases turned out to be very small.

Moreover, publication of names has been tried in several State and locally financed programs and abandoned because it did not reduce the number of people receiving payments and it did increase administrative problems.

But these facts are not generally known. And the general public does not realize that the eligibility of each person receiving assistance must be rechecked at least once a year by the State government, as a condition for receiving Federal funds. Nor is it widely understood that full information about recipients has always been available to boards of public welfare, legislative bodies, and others responsible for insuring efficient administration of the programs. Because many people do not know these facts, thousands of children and their families may be humiliated by having their poverty made a matter of public gossip.

Children are being injured also by well-intentioned but extreme measures being taken in some places to force support from fathers who have deserted or abandoned them. In some places, children become ineligible for public aid if a court order for support has been entered against the father, whether or not the support is paid, and whether it is adequate or not. Sometimes an unemployable man with a long history of cruelty to his family is returned to the home, thus not only depriving the children of the benefits of the Aid to Dependent Children program, but also creating a home environment of fear and terror. In some cases, an alcoholic or otherwise unemployable father is jailed for nonsupport, and the whole sordid story is published in the local papers, to the great humiliation of the family and without any saving to the taxpaying public —in fact, at an extra cost for prison care.

The child born out of wedlock, handicapped to begin with by the circumstances of his birth, has been under particularly heavy attack in connection with Aid to Dependent Children, because many people have been led to believe that some women deliberately enter into unwed motherhood as a means of becoming eligible for public assistance. Proposals are being seriously made to deny assistance to unmarried mothers, to put all such children in institutions, and to jail the mothers. These indicate of course, how little the general public understands the problem of illegitimate birth.

Of all the steps toward undermining the public-assistance program, the one that affects the most children is the arbitrary reduction in the amount of assistance that has been made in some places. In one State, for example, no more than $50 a month can now be given to any one family, no matter how many children are in the family and no matter how great is their need. For the Nation as a whole, the average payment per person in the Aid to Dependent Children program is $21 a month. The goal of the program —to keep children at home with a parent or close relative and to make it possible for them to complete high school—is becoming increasingly unattainable as prices rise and the gap widens between what is needed and what is received.

If the public is to evaluate the strengths and weaknesses of this program and to find sound ways of meeting the unmet needs of the children the program is designed to serve, they will have to understand the program better. Everyone who works with children has a stake in telling the people in the community the truth about these programs and in preventing the spread of misinformation that leads to measures injurious to many children.

Facts about the Aid to Dependent Children program that all workers in fields concerned with children should know are given on page 87.

Reprints in about 6 weeks

CHILD-LABOR STANDARDS RAISED IN FIVE STATES; LOWERED IN EIGHT

BEATRICE McCONNELL

STATE LEGISLATURES meeting in 1951 enacted laws concerning child labor that reflect the pressure for manpower throughout the country. Although some advance occurred, a discouraging tendency toward relaxation of labor standards can be seen.

The legislatures of 44 States, Puerto Rico, Alaska, and Hawaii met in regular session in 1951. In a number of these States comprehensive child-labor bills, raising standards, were introduced, but none passed. On the other hand, acts lowering child-labor standards or authorizing relaxations of such standards were passed in eight States. Four of these acts—in Indiana, Ohio, Utah, and Wisconsin—are called emergency measures, and are limited to a definite period of time.

The Indiana and Ohio acts relax night-work standards for girls 16 and over. The Indiana act, effective until March 15, 1953, permits girls of 16 and 17 to work until 9 p.m. instead of 7 p.m. in all occupations except those determined by the State commissioner of labor to be hazardous. The Ohio act, effective until September 1, 1953, permits girls of 16 and 17 to work until 9 p.m. instead of 6 p.m., and suspends the prohibition of night work between 10 p.m. and 6 a.m. for girls 18 to 21.

In Utah the minimum age is lowered from 16 to 14 for employment outside school hours in the first processing of agricultural products, and, if so decided by the State commissioner of labor, in other nonhazardous industries. This act is effective until the end of the national emergency or February 15, 1953, whichever occurs first.

Under the Wisconsin act, the State industrial commission is authorized, during the period covered by the Selective Service Act of 1948 or other compulsory military-service law, to permit boys of 12 to engage in house-to-house street trades. The former minimum age for such work was 13 years.

Additional backward steps

The four other acts lowering standards set no expiration date. An amendment to the North Carolina child-labor law permits girls of 17 to work until 10:30 p.m. as ticket takers or cashiers in motion-picture theatres. Florida and Hawaii laws permit children of any age to work in making motion pictures, although in Hawaii this is limited to times when children are not legally required to attend school. Under all three of these acts, the State commissioner of labor is authorized to set conditions under which the minors may be employed.

An Alaska act suspends the 8-hour day and 40-hour week for minors 16 and 17 for work during school vacations, provided the work is in accordance with the prevailing wages and hours of the particular industry in which they are employed. The act also lowers from 18 to 16 the age at which a girl may be employed in a restaurant.

Along with these backward steps, a few advances were made, for amendments to the child-labor laws of five States raised standards to some extent. The Delaware child-labor law now requires that age certificates be obtained for minors of 16 and 17. The law formerly required that employment certificates be obtained for minors under 16, and age certificates were issued for minors of 16 and 17 only upon request. Now 22 States, the District of Columbia, Hawaii, and Puerto Rico require certificates for minors under 18 seeking employment, and one other State requires them for minors under 17.

In a New Hampshire act the 14-year minimum-age standard of the child-labor law was extended to include all occupations except agriculture and domestic service, instead of applying only to specified occupations. An amendment to the California workmen's compensation law provides that benefits under the act for minors injured while illegally employed should be

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It is in order to protect children like this that the President's Commission on Migatory Labor recommended that all State child-labor laws be made fully applicable to agriculture

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FOR THE CHILD AS AN INDIVIDUAL

Case workers in health programs help to meet children's social and emotional needs

HELENE SENSENICH LIT

IN RECENT YEARS health agencies have been doing more and more to meet the needs of the individual. An example of early recognition of these needs is found in the efforts made by early child-health conferences and prenatal clinics to preserve the health of mother and child. A long step toward meeting the patient's individual needs was taken a decade and a half ago, when Federal-State programs for crippled children were established under the Social Security Act, aiming to provide complete medical care for children with crippling conditions. As time went on, and these programs were broadened to include not only the conditions that are known as orthopedic crippling, but also certain other conditions—rheumatic fever, cerebral palsy, epilepsy, and others, the trend toward individual care continued. And throughout the years, health agencies had become concerned with the individual needs of adults with tuberculosis, cancer, or heart disease. Creation of State mental-health program also indicates recognition of the patient's individual needs.

A clinic physician has asked the medical social worker to help a mother who is worried about the treatment he has recommended for her child. She will talk these worries over with the worker and will have her help in planning for treatment and in carrying it through.

Through what we have learned from many and various programs, we now see patients more clearly as persons, as human beings with social and emotional needs. We know that specific treatment for a twisted leg or a swollen joint is not enough. We realize how strongly a child's physical well-being is influenced by his feelings about his family, about his school life, and about his playmates.

As we recognize more and more how closely the individual's physical, social, and emotional needs are interrelated we can see better how necessary is teamwork between the members of various professions who are trying to help him to return to health. The doctor, the nurse, and the medical social worker are members of the team that helps many children. And often other workers play an important part on the team, such as the nutritionist, the physical therapist, the occupational therapist, and the speech therapist.

When the crippled children's services first went into effect, only a few case workers were employed in State health agencies. But these services, emphasizing individual medical care, brought out forcibly the need for attention to such children's social and emotional needs, and more and more medical social workers were brought into the programs. In the fiscal year 1951-52 practically every State health agency has medical social workers on its staff.

But even now such workers are

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This article is based on a paper given by Mrs. Lit at the seventy-eighth annual meeting of the National Conference of Social Work.

relatively few and the number of children who need their services is great. And so the amount of individual work with children is still limited. Besides, much emphasis has been placed by medical social workers on such important services as consultation with other professional staff, and participation in program planning and community planning. A great deal could be said about the valuable work that such workers do in these fields.

In order to make the best use of the time available for giving attention to individual children, efforts are made to provide case work at times when the need of the child and his parents is most acute. One of these times is when the child is brought into an itinerant or "field" clinic. It is here that an adolescent would-be football player is told that he needs to go to a hospital and be placed in a cast. It is here that a mother learns that her baby —a baby she did not want—has a congenital deformity; and she is terrified by the idea that the deformity is the result of her not taking good care of herself during pregnancy. It is here that a little girl who has been brought in just "feeling tired" suddenly faces a diagnosis of rheumatic fever, with the accompanying fears and the threat of separation from home.

All these situations, and a multitude of others, come to the attention of the medical social worker when a field clinic is being held. The children's need for help is immediate, and the workers must give the most help possible within the confines of the clinic, bearing in mind that the community may have no resources for continuing skilled case-work service.

Even though the worker may have no opportunity to continue her services after the clinic is over, she can still do much to help the child, for the impressions that she gains from her interviews with the child and his parents contribute greatly to the clinic's plans for helping the child. As part of the health team, she shares her impressions with the other members of the staff, so that the final plan for medical care will take into consideration the total needs of the child. And in order that his care may follow a continuing plan after he leaves the diagnostic clinic, the medical social worker also conveys her impressions to the staff of the hospital or other special facility where the child is to go for treatment.

To give help when it is needed most

If the State program has a very limited medical social staff, the worker tries to help the child through the most crucial periods of his treatment. And so she may give some service to children while they are in the hospital. This has been done most frequently in State-operated crippled children's hospitals or cerebral-palsy treatment centers. Occasionally a limited service is given to a child who is being treated in a hospital that has no social-service department. When giving this service the worker collaborates closely with members of the hospital staff and the local health department. In some treatment centers, where the State agency is able to allow the worker only 2 or 3 days' service a week, or sometimes less, the service she gives must, obviously, be limited.

The service given by a medical social worker to children in a hospital includes, for example, the help she can give to Bobby, who had expected to graduate from school this year at the head of his class. But on account of the length and severity of his illness he will not be able to graduate at all until some future time. Then there is 15-year-old Jessie, who is about to leave the hospital after recovering from severe burns, but who can't bear to go home because not all the scars on her face have disappeared. The worker learns from the girl that part of her trouble is that she feels that she can no longer compete with her attractive sister. It is easy to see how much this child needs help.

Case-work service given by staff of State health agencies, limited though it is, has done much to bring to the fore the effect of social and emotional factors on children's health. It has demonstrated, on an individual basis, the need for considering what there is in Johnny's

The medical social worker is introduced to Mary and her mother by a public-health nurse, who has found that they need case-work help in adjusting to a long period of care at home.

family relationships, and in Johnny himself, that will have to be taken into account before the treatment he receives can be truly helpful to him. As a result of this, and as a result, too, of the increased awareness in public health of the patient as a person, many of the medical social services that were originally centered in crippled children's programs are provided also in maternal and child-health and other public-health programs.

Local health departments employ case workers

Similarly, increases in development of medical social services have taken place in county and city health departments. In some places State medical social workers had been giving services at diagnistic clinics, and local staff members had become interested in having this type of service available in their own department. In others, through consultation with medical social workers, health officers and their staffs had become increasingly aware of the contribution that medical social work could make to public health, and as a result local health departments have established medical social positions.

The county or city health department represents a rapidly developing field for the practice of medical social work. As a rule, the medical social worker offers case-work service on a "generalized" basis. She is not limited to one program or one diagnostic group, such as crippled children's services, or tuberculosis control, but carries responsibility for service in a variety of health department programs. Of course the number of these programs varies considerably from one department to another, but they may include maternal and child health, hearing, and speech; as well as syphilis, tuberculosis, cerebral palsy, rheumatic fever, and so forth. The greatest limiting factor is the worker's time and strength.

In order that the worker's services may be used with the best results, it is necessary to be selective in giving help where it is needed most. Priority, of course, should go to patients whose illnesses or the treatments recommended are most likely to bring about social and emotional tensions in the patient himself or in his family.

For example, a child with cerebral palsy and his parents would be especially in need of service—the child's parents, to help them to accept the child and his disability; and the child, to help him learn to accept himself; and both child and parents, to help them to face the long period of training that will be necessary. Again, an adult facing a diagnosis of tuberculosis, requiring him to enter a sanatorium, should certainly have help in planning for long-time care away from his home and family.

Since long-time care is hard to carry out, a family may have a rough time unless they receive help; and if the plan seems too difficult it may not be carried out at all. In order that this may not happen, it is urgent that something be known of the patient and his family at the time the plan is evolved, so that consideration may be given to their special needs.

To meet this situation the medical social worker gains information about the family, its strength, and its needs, on which a kind of social diagnosis can be based. She carries responsibility for determining the social and emotional factors that surround the illness and affect the ability of the patient and his family to carry through the plan for medical care.

In the course of her study of the patient and his family, the medical social worker is able to give them some help; but, what is also important, she contributes her knowledge of their social needs to the other members of the health team, so that the team can take these into account when planning for the care of the patient and when carrying out that plan. The medical social worker may continue to offer intensive case-work help to the patient, if this proves to be necessary.

In many cases the medical social worker will recognize needs in a family situation that can be met only through collaboration with workers outside the health agency. Here she will use her knowledge of community resources in order to help the family.

For example, she may see a child who, after he has completed hospital treatment, will need to continue under close medical supervision for several months. But his home is in a community far from the center. In such a case the medical social worker may plan with a child-welfare worker, who would make it possible for the child to stay in a foster home as long as necessary, and would help him in his adjustment to it.

Again, the medical social worker may be asked to help a mother who is about to go to a hospital for an operation, and there is no one to care for her children at home in the daytime. In this case, the medical social worker may plan with a social agency for the services of a homemaker, who will help keep the family together until the mother can again do her housework.

According to the individual's needs, the medical social worker may need to plan with many types of agencies, such as a child-guidance clinic, a vocational-rehabilitation agency, and a welfare agency that will provide financial or general case-work assistance.

In situations needing these various types of help, the medical social worker helps the family to understand and accept the services of the other agencies, and continues helping the family in relation to its health problems as a part of the total plan for meeting their special needs.

Case-work service may forestall trouble

In addition to these services, we find that increasing emphasis is being placed on what we have rather haphazardly called "preventive" case work. I am not sure that the term is valid, or even really descriptive of what we mean; it is somewhat casually borrowed from the idea of preventive medicine. It has been applied to some of the case-work services offered in both

child-health and prenatal clinics.

An example of this type of work: Here is 3-year-old Davy. He shows no evidence of illness, nor of any outright "behavior problem." But his mother handles him with great tenseness; she mentions his restlessness, his poor eating, and his poor sleeping. The case worker recognizes that he may very well be reflecting his mother's tensions. And it is no surprise to the worker when the mother tells her about marital troubles, or her parents' desire to "take over." The service offered the mother is social case work; and help may be needed on a short-term basis, or a long-time and intensive basis. Its so-called "preventiveness" rests on the fact that as yet this social or emotional stress has not been reflected in illness, nor has the stress become so acute as to cause the mother to seek help from a community social agency.

This whole area of medical social service has been expanding in recent years and will probably continue to do so as the World Health Organization's definition of health as a state of complete mental and social well-being, as well as physical, continues to gain interest and acceptance. It is impossible, however, to predict the future, or to speak with assurance about what the trends of today may mean in terms of medical social work practice tomorrow. Some of the developments that we have noted, however, give evidence of an increasing awareness of those particular social and emotional needs that can best be met through the specialized service of a case worker.

The world is becoming increasingly interested in the health of the child, and in all the factors that might influence the maintenance of his health or affect his medical care. With the broader definition of health, these factors are of interest to health agencies. Certainly, with this concern for the needs of the individual, it is not surprising that the demand for medical social workers exceeds the supply.

Reprints in about 6 weeks

AWAY FROM HOME

(Continued from page 85)

need day care as a supplementary service, a means of strengthening the family unit.

Placement agencies are showing interest in day care given in foster-family homes, which suggests that this type of daytime care may become a permanent part of child-caring services in communities.

Much of the need for day care stems from the fact that more women are equipped to work outside the home. In many communities, however, facilities are entirely inadequate to care for children when mothers must be providers. State funds are available for day care in only two States, and municipal funds in a few large cities.

We must inform the public

An important aspect of day care has to do with adequate licensing. Many nurseries recognize that absence of legal safeguards is a serious threat to their programs. In day care, as in other child-welfare programs, when harmful, substandard programs exist, adequate programs will suffer through comparisons as to cost, hours, and so forth.

I have mentioned some of the major developments in certain areas of foster care. I am conscious of omissions. I might have mentioned, for example, the housing of children in jails while waiting for a court decision on their placement. One can only be shocked at our failure to provide adequate foster care for such children, and equally shocked that preventive and protective measures are so inadequate as to permit ever-increasing numbers of children to come to the attention of the courts. There are other critical gaps that are scarcely being touched.

The final stress to be made here is that better methods, improved understanding, willingness to change, more effective planning, will avail nothing if we are unwilling to face realistically the distinct problem related to all of these trends. I refer to the need to tell the public at large honestly and fully what is involved in a good child-care program in any community and what it costs.

We all know that more of both voluntary and public funds are necessary for an adequate child-care program. We agree also that the public has a right to know how much of a job its funds are accomplishing; how much more needs to be done; and how much it will cost. Indeed, our present inadequate methods of explaining how these funds are used have placed the public unwittingly in the role of accepting and condoning poor service in many areas.

Confusion is also encouraged through failure to make clear that in many instances public funds are subsidizing large portions of agency budgets. A private child-placing agency receiving large amounts of public funds on a broad subsidy basis cannot be an independent and free agency in setting and carrying out its policies. Strong public and strong private child-care agencies are essential in our society, and we have a responsibility to inform the public as to the requirements of coverage and financing of both. Both have joint responsibility for community planning to meet the child-care needs in any community or State, and for working out together their cooperative functions, community by community and State by State. Until this is done, progress in child-care services is in jeopardy.

Not new at all is the need to tell the community what a good program costs and what are the responsibilities of public and of private agencies. We have faced this need in different ways at different times —often, as now, half-heartedly or incompletely. We must change this. We must face facts in an atmosphere of complete mutual respect, unhampered by our special interests or set ideas. And we must face them with our eyes clearly on the welfare of children.

Reprints in about 6 weeks

CHILD LABOR

(Continued from page 89)

increased by 50 percent. This makes 17 States and Puerto Rico that provide additional compensation for such minors.

A temporary improvement has been made in Ohio. In the emergency act providing for temporary relaxation of the provisions concerning maximum working hours for girls, there is included also an 18-year minimum-age requirement, applicable to a considerable number of hazardous occupations. This requirement, however, is effective only for the period of the act— until September 1, 1953. In Illinois penalties are materially increased for employment of children under 14 in certain types of public entertainment.

School-attendance requirements, which are closely related to the regulation of employment of children, were also strengthened in a few States. An amendment to the Illinois law eliminates the conflict between the compulsory-attendance provisions and a 1947 amendment to the child-labor laws. The minimum school term in South Dakota is extended from 8 to 9 months. In Wisconsin the former exemption from school attendance for children living more than two and a half miles from a school was deleted.

Although the final enactments for 1951 were not entirely adverse, it is clear that present and impending pressures to obtain more workers threaten to undermine hard-won gains made in former years. Child-labor and school-attendance standards serve as a guide in preventing harmful employment of boys and girls. They protect youth from the consequences of their own inexperience. If employers, schools, parents, unions, and the community as a whole join in supporting full maintenance of child-labor and school-attendance laws during the present emergency, this cooperative action will aid in conserving and building up the capacities of boys and girls for their future responsibilities.

IN THE NEWS

Birth registration. The chances are 98 out of 100 that today's baby will have a birth certificate, according to preliminary results of a Nation-wide test. The test, the second of its kind in our history, was conducted by the Public Health Service of the Federal Security Agency, and State health departments, in cooperation with the Bureau of the Census, Department of Commerce.

In this birth-registration test, the April 1950 census records of 800,000 babies born during the first 3 months of 1950 were matched against the birth-registration records.

In 1940, when the first national survey was made, it was found that 92.5 percent of newborn babies were registered, compared with 97.8 in 1950. For every hundred babies born in 1940, 7 were not registered. In 1950 only 2 in a hundred were not registered. Much of the gain is due to greatly improved registration among nonwhite groups. Only 7 in every hundred nonwhite infants were unregistered in 1950, compared with 18 per hundred in 1940.

State and local registrars are already studying the results on a county-by-county basis. Most States with problem areas have indicated that they intend to find out the specific reasons that birth certificates were not filed, so that promotional campaigns may be tailored to fit the conditions responsible.

The Children's Bureau in 1914 published as its second bulletin, "Birth Registration; an aid in protecting the lives and rights of children." In 1915 the Bureau of the Census established the Birth-Registration Area including 10 States and the District of Columbia. Year by year State health agencies and citizens' organizations worked for State birth-registration laws until in 1933 all the States were included in the birth-registration area. The 1950 test shows that the doctors, midwives, and hospitals that file birth certificates and the registrars of vital statistics that record them have now achieved substantially complete birth registration in the United States.

Married women employed. More married women were working in 1951 than ever before in the Nation's history, according to advance data from a sample survey by the Bureau of the Census, Department of Commerce, released December 26, 1951. In April 1951 more than 10 million married women were in the labor force (employed or looking for work). This is about 1 million more than in March 1950 and about 1½ million more than in April 1949. No figures are yet available on how many of these women have children.

Korea. Clothing for at least 240,000 Korean children is in prospect, with the arrival in Korea of two shipments of cotton cloth, more than 2,400,000 yards, from the United Nations International Children's Emergency Fund (UNICEF).

The cloth is being allocated by the Central Relief Committee, including representatives of the Government of the Republic of Korea and the United Nations Civil Assistance Command. Distribution is to be made to orphans and refugee children in institutions and in needy families.

Children-to-children. Articles of clothing sent as gifts by American children to India as a gesture of friendship have been distributed to children in Delhi at a ceremony arranged by "Balkan-ji-bari" (a nation-wide children's organization). Balkan-ji-bari will reciprocate by sending good-will tokens to American children.

Scholarships. If you know some one who would like to be a worker in some field concerning children but who cannot afford to pay tuition in a school of, say, social work or nursing, why not look into the possibility of a scholarship? The Office of Education, Federal Security Agency, has recently published a bulletin that gives information on financial aids for undergraduate and graduate study. The bulletin is titled, "Scholarships and Fellowships available at Institutions of Higher Education." (Bulletin 1951, No. 16. 248 pp. For sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. 55 cents.)

To Our Readers—

We welcome comments and suggestions about **The Child.**

FOR YOUR BOOKSHELF

THEY WORK WHILE YOU PLAY; a study of teen-age boys and girls employed in amusement industries. U. S. Department of Labor, Bureau of Labor Standards, Bulletin No. 124. Washington, 1950. 26 pp. For sale at Superintendent of Documents, Government Printing Office, Washington 25, D. C. at 15 cents. 25 percent discount on orders of 100 or more. Single copies free at Bureau of Labor Standards.

Nearly 200,000 young workers under 18 — nearly 80,000 under 16 — are employed in various industries furnishing public amusement. This little bulletin gives facts concerning the extent and type of young workers' employment, their working conditions, and a summary of State child-labor standards and their administration.

Although important advances have been made during recent years in protective State legislation for young workers, youngsters employed in the recreational service industries have not shared to the same extent as other young workers in the benefits. Their work is largely part-time employment, carried on in the traditional leisure-time hours of the general public — late afternoon, evening, and on Saturday and Sunday. And because of the local nature of their employment, few children who work in amusement industries are covered by Federal child-labor legislation.

GOOD SCHOOLS DON'T JUST HAPPEN; a guide to action for life-adjustment education. One of a series of Better Living Booklets. Science Research Associates, Inc., 57 West Grand Avenue, Chicago 10, Ill., 1951. 26 pp. Single copies 10 cents; 100 or more 5½ cents each.

Life Adjustment Education is a strong movement to adapt public education to the needs and opportunities of all youth in our changing world. It is fostered jointly by the Commission on Life Adjustment Education for Youth, and the Office of Education, Federal Security Agency. This booklet, which was prepared by a lay advisory committee working with Office of Education staff, is for the use of interested community leaders.

Part 1 points out changes that have made the entire community the laboratory of modern education. It provides a simple scoring technique for evaluating the extent of community acceptance of the goals of a good school, such as helping youth to acquire the basic tools of learning; to select activities that prepare them for life; to prepare for, get, and hold a job; to maintain mental health and physical fitness; to budget, save, and invest wisely; to do what is right; to be a good citizen; and to be a good family member.

Some of the problems that must be solved by the school and the community are taken up in part 2 of the booklet. It lists questions designed to bring out the facts about each school and community.

Part 3 suggests what community leaders can do to help meet the life-adjustment needs of youth in their own communities.

References for further reading are included.

Edith Rockwood

CALENDAR

Mar. 2–8. Save Your Vision Week. Information from Department of Public Information, American Optometric Association, Jenkins Building, Pittsburgh 22, Pa.

Mar. 3. Child Study Association of America. Annual conference. New York, N. Y.

Mar. 3–5. National Cancer Conference. Second national conference, Cincinnati, Ohio. Sponsored by the American Cancer Society and the National Cancer Institute, Public Health Service, Federal Security Agency.

Mar. 5–7. National Conference of Superintendents of Training Schools and Reformatories. Twenty-ninth annual conference. New York, N. Y.

Mar. 13–14. National Health Council. Thirty-second annual meeting. New York, N. Y.

Mar. 16–22. Camp Fire Girls National Birthday Week. Information from Camp Fire Girls, Inc., 16 East Forty-eighth Street, New York 17, N. Y.

Mar. 17–20. United States-Mexico Border Public Health Association. Tenth annual meeting. Monterrey, Nuevo Leon, Mexico.

Mar. 19–21. National Society for the Prevention of Blindness. Annual conference. Pittsburgh, Pa.

Mar. 29–30. American Psychosomatic Society. Ninth annual meeting. Chicago, Ill.

Mar. 31–Apr. 3. Council of Guidance and Personnel Associations. Annual meeting. Los Angeles, Calif.

Mar. 31–Apr. 3. National Vocational Guidance Association. Annual convention. Los Angeles, Calif.

Mar. 31–Apr. 4. Fifth American Congress on Obstetrics and Gynecology. Cincinnati, Ohio. Sponsored by the American Committee on Maternal Welfare, 116 South Michigan Avenue, Chicago 3, Ill.

Mar. 31–Apr. 6. National Boys' Club Week. Information from Boys' Club of America, 381 Fourth Avenue, New York 16, N. Y.

Area conferences, National Child Welfare Division, American Legion:

Mar. 6–8, 1952. Area C.—Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, Oklahoma, Panama, South Carolina, Tennessee, and Texas. Little Rock, Ark.

Mar. 14–15, 1952. Area A—Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Portland, Me.

Regional conferences, American Public Welfare Association:

Mar. 6–8. Southwest region. Dallas, Tex.

Apr. 6–8. Central Region. St. Louis, Mo.

Aug. 20–22. Mountain region. Cheyenne, Wyo.

Sept. 2–4. West Coast region. Victoria, B. C., Canada.

Oct. 9–11. Northeast region. Philadelphia, Pa.

Regional conferences, Child Welfare League of America:

Mar. 13–15. Southern Regional Conference. Raleigh, N. C.

Mar. 31–Apr. 2. Central Regional Conference. Detroit, Mich.

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Cover, Philip Bonn for Children's Bureau.

P. 82, General Services Administration (formerly Federal Works Agency).

P. 85, George Jones for Children's Bureau.

P. 89, Library of Congress photograph.

Pp. 90 and 91, Children's Hospital, Washington, D. C.

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In This Issue

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Reprints available

A limited number of copies of the following reprints from **The Child** are available for distribution. Single copies may be had without charge until the supply is exhausted.

There's a Big Job Still to Do to Save Infant Lives (map).

Adolescents Have Special Health Problems. By J. Roswell Gallagher, M.D.

America Welcomes Displaced Orphan Children. By I. Evelyn Smith.

Arkansas Works to Improve Its School Children's Health. By Jeff Farris.

Attitudes Toward Minority Groups. By Annie Lee Davis.

Baltimore's Temporary Group Home Helps Troubled Children. By Dorothy Curtis Melby.

Chicago's Public Housing Program Helps to Save Babies' Lives. By J. S. Fuerst and Rosalyn Kaplan.

Children Can Be Helped to Face Surgery. By Ruth M. Pillsbury, M.D.

Children and Youth Are Citizens. By Stanley E. Dimond.

Citizens Help a Juvenile Court. By Charles H. Boswell.

Connecticut Sends Handicapped Children to Camp. By Ellen E. Ogren.

Coordinated State Planning to Combat Poliomyelitis.

Day-Care Centers and Nursery Schools Have the Same Goals. By Mary Elizabeth Keister.

Emotional Aspects of Convalescence. By Milton J. E. Senn, M.D.

Fluoride Technique Demonstrated in Radio Program.

For Better Care of Premature Babies.

For the Child With No Family of His Own. By Almeda R. Jolowicz.

For the World's Children. By Ruth Crawford.

Harlan County Plans for Its Boys and Girls. By Amber Arthun Warburton.

Learning to Live Together. By Katherine Glover.

A Look at Our Training Schools. By Richard Clendenen.

Memphis Attacks Its Rheumatic-Fever Problem. By James G. Hughes, M.D.

New Haven Hospital Offers Education for Childbirth. By Herbert Thoms, M.D., and Edward Foord, M.D.

A new Look at Child Health. By Brock Chisholm, M.D.

Parents Can Be Helped to do a Better Job. By Helen Northen.

Prematurity in Relation to Obstetric Care. By A. L. Carson, M.D.

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